Reimbursement processed by

Principal Life Insurance Company
Des Moines, Iowa

FSA

Flexible Spending Account Request for Reimbursement

Please mail completed form to:
Principal Life Insurance Company
PO Box 39710
Colorado Springs, CO 80949-3910
Toll free Nationwide 1-877-FSA-4730
FAX 888-308-5270

Email Claims:
FSAReceipts@exchange.principal.com

Directions for Completing Request Form

1. Complete **Statement of Employee** below.
2. Complete the **Eligible Expenses Section** on Page 2. Indicate the total amount submitted for reimbursement on the bottom line.
3. If you want reimbursement of all or part of a deductible **OR** copayment on a charge which has been received for payment under any medical, dental or vision plan, attach a copy of the explanation of benefits form and indicate in the REIMBURSEMENT REQUESTED column on Page 2 of this form how much you want considered for payment. For all other expenses, attach proof of expense(s) which includes provider's name, date and type of services provided. ***To guarantee payment, your claims must be received in the Service Center no later than 2 business days prior to the pay date.***
4. Please refer to your Summary Plan Description (SPD) for the day of the month your reimbursement will be made and for the minimum amount. All eligible expenses for active or terminated employees for current year must be received **by the deadline in the SPD.**
5. Access your FSA through the personal login section of the Principal Financial Group internet site, www.principal.com. This is a secure site so follow the automated process under PIN/Password Services to obtain your personal identification number (PIN).

NOTE: Always retain copies of your proof of expense.

Statement of Employee

Employee's name ____________________

Member ID number or Privacy ID number ____________________

current plan year   prior plan year

Employee's address ____________________
Street

____
City   State   ZIP

Employee's employer ____________________

I, the undersigned, request reimbursement for the eligible expenses listed on Page 2 for myself and any eligible dependents. I certify these expenses are eligible for reimbursement under the Flexible Spending Account sponsored by my employer. I have not been and will not be reimbursed for these expenses from this or any other benefit plan and have/will not include them as itemized deductions or as a tax credit on my personal income tax returns.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for accident and health insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

These statements are true and complete to the best of my knowledge.	Signature of employee	Date

Please furnish a daytime telephone number in case we need to reach you.	Email address

Eligible Expenses Section on Page 2

Eligible Expenses Section

Eligible expenses	Patient and relationship to employee	Provider of service and date of service	Reimbursement requested
Health Care			
1. Medical			$
			$
			$
			$
			$
2. Dental/Vision			$
			$

Dependent Care
(child, spouse, parent)

Dependent's name, age, and relationship to employee

____

____

____

Provider's and facility's name ______________________________

Date of service provided ____________________ Cost of service $ __________

Date of service provided ____________________ Cost of service $ __________

Date of service provided ____________________ Cost of service $ __________

Date of service provided ____________________ Cost of service $ __________

Total dependent care amount submitted for reimbursement $ __________

____
Dependent care provider's signature

Total amount submitted for reimbursement $ __________